STATE OF MICHIGAN
CIRCUIT COURT FOR THE 30TH JUDICIAL DISTRICT
INGHAM COUNTY

LINDA A. WATTERS, COMMISSIONER,
OFFICE OF FINANCIAL AND INSURANCE
SERVICES FOR THE STATE OF MICHIGAN,

Petitioner,

v

THE WELLNESS PLAN,
a Michigan health maintenance organization,

Respondent.
_____/

File No.: 03 1127 CR

Honorable William E. Collette

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REHABILITATOR'S BRIEF AS TO CLAIM PRIORITY DETERMINATION

Linda A. Watters, the Rehabilitator of The Wellness Plan ("TWP"), through her attorneys, Zausmer, Kaufman, August & Caldwell, P.C., files this brief on the issue of the respective priorities to be assigned to claims filed against TWP.

I. STATEMENT OF FACTS

A. General Background

TWP was placed into rehabilitation by this Court on July 1, 2003. Order Placing The Wellness Plan into Rehabilitation, Approving the Appointment of a Special Deputy Rehabilitator,

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and Providing Injunctive Relief, dated July 1, 2003 ("Rehabilitation Order").[1] At the time it went into rehabilitation, TWP was a full-service Health Maintenance Organization ("HMO"), serving approximately 117,505 members. Approximately 107,200 of the members were Medicaid service recipients, to whom TWP provided services under contract with the State of Michigan, with the remaining approximately 10,300 members being commercial subscribers. Most of the members resided in southeastern Michigan, primarily in the City of Detroit, but there were also members in the Muskegon and Flint areas. Verified Petition of the Michigan Commissioner of the Office of Financial and Insurance Services for: Order of Rehabilitation, Appointment of Deputy Rehabilitator, and Injunctive Relief, dated July 1, 2003. The Rehabilitation Order required participating providers to continue caring for TWP members the rehabilitation period. On July 21, 2004, rights to service the members of TWP were sold, pursuant to an order of this Court, to several other HMO's. Order Approving the Rehabilitator's Plan to Sell the Right to Serve Wellness Members, dated July 21, 2004.

After selling the rights to serve the members, the most valuable assets remaining at TWP are the operating health clinics. TWP has continued to operate, following the sale of its membership, as a health service provider in the City of Detroit, serving mainly low-income and indigent people, most of them Medicaid recipients. In doing so, it provides a essential service, as there is a critical shortage of medical services for low-income people in Detroit already. If TWP were not in existence

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[1] Unless otherwise specified, all court documents referenced are those in this case. Because all such documents are in the Court's file and are available to all parties and to the public on the State of Michigan's website at: http://www.michigan.gov/cis/0,1607,7-154-10555-13251_25450--,00.html, copies of most of the referenced documents are not attached to this Brief.

to provide these services, there could well be a crisis in the provision of medical services in low-income areas of Detroit. Affidavit of Stanley Kirk, attached as Exhibit A.

The Commissioner as Rehabilitator, under the supervision of this Court, is proceeding rapidly in her efforts to complete the Rehabilitation of TWP. On June 8, 2005, as the next major step in the Court-supervised rehabilitation process, a hearing will be held to determine the priority of claims. It is the goal of the Rehabilitator to complete the financial rehabilitation of TWP as expeditiously as possible in order to insure continuity of medical services to its patients, most of whom are low-income Detroiters, and to pay existing claims against TWP as expeditiously and fairly as possible.

B. The Medical Malpractice Claims

Approximately fifty persons have filed medical malpractice claims or potential claims against TWP. Facts with respect to some of these claims are set out in the various briefs filed on behalf of malpractice claimants. Although the Rehabilitator does not accept all of the factual representations the parties have made in their briefs, they can serve as a basis for placing these claims in context. According to those briefs, most of the malpractice claims involve birth defects, many of which allegedly occurred because of the alleged malpractice of TWP or its employed or contracting physicians and other health professionals. Some of these claims seek multi-million dollar recoveries.

Litigation in almost all the malpractice cases (nearly all filed in Wayne County) has been stayed. Ultimately, these matters will be presented to this Court for resolution. The Rehabilitator and TWP are contesting liability in all pending cases. In a relatively small number of them, TWP believes it is certain to prevail, either because a statute of limitations or other procedural deadline lapsed, or because it is apparent that the wrong party is being sued, with TWP personnel simply not having been involved in the alleged malpractice. In the vast majority of the cases, though, whether

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the malpractice claimants will prevail against TWP, and, if so, in what amount, will have to be determined by the litigation process.

TWP has a self-insurance trust fund that has been in place for over a decade and a half and that has paid for malpractice claims filed against TWP. In a separate petition, the Rehabilitator maintains that malpractice claims should continue to be paid exclusively from this trust fund, plus any insurance that may prove to be available to pay claims.[2] If this argument is accepted,[3] the question of the priority to be assigned to malpractice claimants could be moot, as they will be paid from separate assets not available to pay any other claims, while in turn they will not be able to look to the general assets available to pay other claims. Therefore, the Rehabilitator's argument as to the priority to be assigned, in general asset distribution, to payment of malpractice claims, is really a contingent one, offered in the event that the Rehabilitator does not prevail in its petition with respect to payment from the trust fund. Nevertheless, some general knowledge of the trust fund and how it works is helpful for an understanding of TWP's potential liability to malpractice claimants.

C. The Trust Fund

The trust fund was created by a Trust Agreement between TWP, then known as Comprehensive Health Services of Detroit, Inc., and National Bank of Detroit, now BankOne, on December 31, 1986. Comprehensive Health Services of Detroit, Inc. Self-Insurance Plan and Trust Agreement, as amended ("Trust Agreement"), attached as Exhibit C. The Trust Agreement has been amended a number of times. Most of the amendments were technical, although some were

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[2] At this time, the Rehabilitator's understanding is that it is uncertain whether excess insurance is available for payment of pre-rehabilitation claims. Further, review of the potential for some excess insurance coverage is ongoing.

[3] The Commissioner will be filing a separate brief addressing this issue.

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substantive, involving the dollar amounts of allowable claims and the types of claims that can be covered.

The dollar limits on claims paid through the trust fund have varied over the years, so there may be some distinction between the amounts available for payment depending on how old the claims are. The fund pays valid claims not only against TWP, but also its employee and contracting physicians and other professionals against whom malpractice claims are filed. The current amounts of payable claims stated in the trust fund documents are as follows:

> With regard to covered Professional Liability Claims based upon occurrence, no payment shall be made from the Trust Fund in excess of $100,000 for any one covered Professional Liability Claim against one or more persons, and $300,000 in the annual aggregate for all such claims, in the case of covered persons other than The Wellness Plan and, in the Case of The Wellness Plan, $3,000,000 for any one covered professional liability claim and no limit in the annual aggregate for all such claims. It is specifically understood and agreed that the Trustee shall have no obligation, absent a specific directive from TWP, to purchase any excess liability insurance coverage; however, the Trustee is authorized to purchase and maintain such excess liability insurance coverage and pay the premiums, for the cost of said insurance coverage, provided same is completed at the express written direction of TWP.

Article VIII of the Trust Agreement creating the malpractice trust fund, as amended effective January 1, 1997 (Exhibit B).

Whether malpractice claimants will look solely to this fund for recovery is an issue that this Court will decide after a full consideration of relevant facts and law. If the Rehabilitator's petition for the separate source payment of malpractice claimants is denied, malpractice claimants will be entitled to look to general assets for payment of their claims. If this happens, given the number of these claimants and the significant recovery being sought, the priority to be given these claims will

be one of the most important issues affecting not only their own recovery but also that of other claimants.

D. Medical Providers and Other Claimants

Most of the other claims filed in this case have been filed by medical providers. With regard to these claims it is important to note that TWP, pre-rehabilitation, was a mixed model HMO. It provided services to members not only through its own staff physicians and other practitioners, but also through a network of providers. TWP members could treat with these providers under contractual arrangements for medical services. These providers did not seek payment from TWP members directly. Rather, TWP paid the providers, which were actually barred from seeking payment (except for agreed co-pays) directly from the TWP members. TWP obtained the money to pay the providers either from premiums paid by TWP members or, in the case of Medicaid patients who formed (and form) a large part of the TWP clientele, from designated Medicaid funds for these patients. Affidavit of Stanley Kirk, Exhibit A. Thus, TWP acted similarly to a traditional insurance company in dealing with network medical providers serving TWP members. The members went to the providers for services; TWP paid the providers; TWP received the money to pay for the services from regular fees, similar to premium payments, paid by the member or their employees, or from funds paid on members' behalf by government agencies.

There were two primary distinctions between the way TWP and traditional insurance companies operate financially. First, if TWP failed to pay a participating provider, the provider is still barred from seeking direct payment from the TWP members, whereas a provider is not barred

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from seeking payment from an insured of a traditional insurance company.[4] Second, payment for medical services given by providers to TWP members always went directly from TWP to the providers, with no checks being written by TWP to its members, because, except for co-pays, members were never billed directly by providers, as sometimes happens with traditional insureds.

Other than the providers and medical malpractice claimants the only party to have briefed the priority to be given its payment is a company that supplied durable medical goods on an as-needed business to TWP and its members. This claimant's business consisted principally of having such durable goods always available for use as needed, including on an emergency basis.

II. LEGAL ARGUMENT

A. The Petition is Ripe for Decision, and Within the Court's Jurisdiction.

The Texas receiver for Texas WellChoice has argued in its brief[5] that TWP has sufficient assets to pay all claimants in full, and that the Court need not determine claim priorities at all. TWP certainly hopes that this proves to be the case, but it may not be.

As some of the medical malpractice claimants have noted in their briefs, there are fifty-plus medical malpractice claims outstanding, most of them for birth defects, and many of them claiming damages in the millions of dollars. TWP is unable to predict at this point what liability if any TWP will have on these claims, and it is contesting liability. However, if the medical malpractice

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[4] If a commercial member sees a physician outside the HMO's provider network, that member may be billed directly. This is not true for Medicaid members, because Michigan law prohibits a provider from billing a Medicaid beneficiary.

[5] The Texas receiver's claim alleges TWP is liable for fraudulent misrepresentation of the financial standing of an affiliated Texas HMO. TWP denies liability as to this claim. Because the Texas receiver does not argue either the merits of its claim or the priority it should receive, the nature of this claim is not addressed any further in this brief.

claimants prevail, with a success even approaching what they hope for, the liabilities of TWP could exceed the $38,324,000 of net assets shown in TWP's 2004 year-end statement. Further, the Receiver is, simultaneous with the pendency of the priority issue, investigating and adjudicating other claims against the Estate. The total amount of claims, therefore, is unresolved. Accordingly, the Rehabilitator has to be prepared for a scenario in which there are insufficient assets to pay all claims one hundred cents on the dollar. The Rehabilitator has a statutory obligation to develop a plan of reorganization for TWP. MCL 500.8114(4). This cannot be done without making recommendations for how, if there is not enough money to pay all claims, the claims shall be paid. By statute, the Rehabilitator makes decisions under the supervision of this Court. MCL 500.8113. Therefore, it is reasonable and permitted for the Rehabilitator, in developing a Rehabilitation plan, to seek the Court's guidance – and provide an opportunity for input by interested parties – on a central legal issue that foreseeably could directly affect the disposition of TWP's assets. *See, e.g., Toy ex rel. Ketchum v Lapeer Farmers Mutual Fire Ins Ass'n,* 297 Mich 174, 184-186 (1941). It would be irresponsible and contrary to her statutory mandate for the Rehabilitator to operate under the assumption that all claims will be paid in full where there is a realistic possibility that this will not occur.

B. MCL 500.8142(1) Provides the Statutory Basis for Determining Claim Priorities.

MCL 500.8142(1) sets out the rules for determining the priority to be given to different types of claims against a delinquent insurer or HMO. The priorities are set out in descending order, with a separate subsection devoted to each priority class. The statutory section is appended to this brief as Exhibit C, and the specific provisions are detailed further in connection with specific points of analysis, but its provisions may be summarized as follows.

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MCL 500.8142(1)(a) gives the highest priority, Class 1, to "costs and expenses of administration." This includes not only administrative expense in the strict sense of the phrase, such as legal and supervisory fees, and employee claims for certain services rendered, but also "[t]he actual and necessary costs of preserving or recovering the insurer's assets." MCL 500.8142(1)(a)(i).

MCL 500.8142(1)(b) gives the next highest status, Class 2, to "all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association." After setting out exceptions irrelevant to this case pertaining to reinsurance and to life insurance, it adds, "That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class."

MCL 500.8142(1)(c) gives Class 3 status to all federal government claims.

MCL 500.8142(1)(d) gives Class 4 status to "[a]ll claims against the insurer for liability for bodily injury, or for injury to or destruction of tangible property that are not under policies," and also to certain types of employee claims.

MCL 500.8142(1)(e) places in Class 5 "[c]laims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors." Only the last portion, claims of general creditors, would appear to be relevant here.

MCL 500.8142(1)(f) gives Class 6 status, with certain limitations, to state and local government claims.

MCL 500.8142(1)(g) defines, as Class 7 claims, "Claims filed late or any other claims other than claims under subdivisions (h) and (i)." MCL 500.8142(1)(h) and (i), which have to do with shareholder claims and other sorts of investments in for-profit insurance companies, are not implicated in this case.

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C. Applicable Rules of Statutory Interpretation

The primary goal of statutory interpretation is to give effect to the intent of the legislature. *People v Stone*, 463 Mich 558, 562; 621 NW2d 702 (2001). In interpreting a statute, the court considers both the plain meaning of a critical word or phrase and its placement and purpose in the statutory scheme. *Sun Valley Food Co v Ward*, 460 Mich 230, 237; 596 NW2d 119 (1999). If the statutory language is unambiguous, it is presumed that the legislature intended the clearly expressed meaning, and judicial construction is neither required nor permitted. *DiBenedetto v West Shore Hosp.* 461 Mich 394, 402; 605 NW2d 300 (2000). When the language of the statute is not plain but is subject to varying interpretations, the court looks to the purpose of the enactment to ascertain legislative intent. *Dean v Dep't of Corrections,* 453 Mich 448, 454; 556 NW2d 458 (1996). The court should apply a reasonable interpretation that best accomplishes the legislature's purpose. *Rowell v Security Steel Processing Co,* 445 Mich 347, 354; 518 NW2d 409 (1994). While case law is often helpful in construing statutory language, the Rehabilitator has located no case law applying Chapter 81 to a delinquent HMO.

Laws that involve insurance are affected with public interest and therefore must be liberally construed in favor of policyholders, creditors and the general public. *Yetzke v Fausak*, 194 Mich App 414, 421; 488 NW2d 222, *app den* 441 Mich 889; 495 NW2d 383 (1992). *See also Att'y Gen'l v Michigan Surety Co,* 290 Mich 33, 43; 287 NW 368 (1939); *DePyper v Safecto Ins Co,* 232 Mich App 433, 441; 591 NW2d 344, *app den* 460 Mich 873; 601 NW2d 100 (1999); *Szabo v Ins Comm'r,* 99 Mich App 596, 599; 299 NW2d 364 (1980). The language of an insurance statute should be construed in the most beneficial way to prevent absurdity, hardship or injustice, to favor public convenience, and to oppose all prejudice to public interest. *Yetzke, supra* at 421. Where the

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legislature has properly delegated authority to an administrative agency to carry out the mandates of a statute, the courts should give great deference to the agency's interpretation of the provision, although they are not bound by it. *Szabo, supra* at 598; *see also Bruhan v Plymouth-Canton Community Schools,* 425 Mich 278, 282-283; 389 NW2d 85 (1986); DAIIE v *Comm'r of Ins,* 119 Mich App 113, 119; 326 NW2d 444 (1982).

D. Principal Points in Controversy Among the Claimants

The chief issue in this case is the respective treatment of medical malpractice claimants and medical care providers. Each class of claimants argues that it is entitled to Class 2 treatment. As set forth below, the Rehabilitator believes that the providers' claims are entitled to be treated as Class 2 claims. This is because with an HMO, as TWP was when it went into rehabilitation, amounts expended on medical services are the "losses incurred" against which the HMO plan insures. Therefore, they precisely meet the statutory definition of Class 2 claims. MCL 500.8142 (1)(b). On the other hand, medical malpractice claims are not losses that the HMO plan was set up to insure its member-patients against. With respect to the HMO plan of insurance, the medical malpractice claimants are not parties who have suffered the sort of "losses incurred" against which HMO membership is designed to insure — namely, medical costs. Rather, within the plain meaning of the statute, they are parties who have suffered "physical injuries." Therefore, their claims fall within Class 4.

The final question briefed is the priority of suppliers of durable medical equipment whose main business has been to service Wellness and its members. This claim is a simple general creditor claim that falls into Class 5.

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E. Medical Service Providers

A number of medical service providers have filed briefs arguing that their claims are for losses incurred as third parties under the contracts or policies of TWP members, and as such, they are entitled to Class 2 status under MCL 500.8142(1)(b). The Rehabilitator agrees with this view.

MCL 500.8142(1)(b) reads:

> Class 2. Except as otherwise provided in this section, all claims under policies for losses incurred, including third party claims, and all claims of a guaranty association or foreign guaranty association. However, obligations of an insolvent insurer arising out of reinsurance contracts shall not be included in this class.

The essential question is what the phrase "claims under policies for losses incurred" means in the context of an HMO delinquency. It is a cardinal rule of statutory construction that if "two statutes arguably relate to the same subject or share a common purpose, the statutes are in pari materia and must be read together as one law . . .. If statutes lend themselves to a construction that avoids conflict, then that construction should control." *People v Webb,* 458 Mich 265, 274; 580 NW2d 884 (1998).

Under this principle, MCL 500.8142(1)(b) and MCL 500.3503, applying the regulations of the Insurance Code to regulation of HMO's, clearly are in pari materia, and therefore must be interpreted consistently. Doing so means determining what sort of loss is incurred under an HMO contract, in the same way that the determination would be made with respect to an insurance policy. To determine what constitutes a "loss incurred" with respect to an HMO policy or contract, therefore, it is necessary to begin by asking what sort of damage or loss an HMO policy or contract protects an HMO member against, just as losses incurred under an insurance policy are determined by looking at the loss or damage the insurance policy protects an insured from.

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The answer to this question is clear, from the state framework for regulation of HMO's, from the way HMO contracts are written, and from the way HMO accounting and financial and actuarial statements (including those of TWP) are prepared. HMO members look to avoid financial loss that would occur if they had to pay for medical services themselves. HMO policies protect them from these losses through the HMO, for a fee, either providing medical services directly, or contracting with third parties who will provide the services. These third parties are then paid directly by the HMO and are prohibited from seeking repayment directly from the HMO members. The only real difference, in this regard, between an HMO contract or policy and a more traditional medical insurance policy is that under a traditional insurance policy, the insured is theoretically initially liable to pay the medical provider[6] and then is reimbursed by the insurance company, while under an HMO policy, the payment is made directly by the HMO to the provider of services, with the HMO member never seeing an actual bill. In both cases, the loss incurred is the same — the cost incurred for medical services. Under a traditional policy, it may sometimes but not always be the insured who suffers this loss, if the insured pays a medical bill before the insurance company writes the check. With an HMO, the loss is incurred by the party that provides the services to the HMO member without being able to seek payment directly from the member; it must look to the HMO for payment. In either event, medical services are the losses. The only difference (if any) is who gets the check to avoid the loss. With an HMO contracting with medical providers, this is a third-party service provider, and the statute specifically recognizes that these claims are covered under Class 2 by

[6] In practice, of course, this initial liability is now frequently waived, with the provider waiting for insurance company payment before seeking reimbursement from the insured.

adding immediately after the phrase "losses incurred," the words, "including third party claims." [7]

On the other hand, HMO members themselves do not suffer losses under their HMO contract. In fact, the HMO contract protects them against suffering loss by not only providing for the rendering of services, but insuring that they will never directly see a bill from contracting providers for services rendered. See Affidavit of Stanley Kirk (Exhibit A); see also MCL 500.3529(3). The losses, then, that are suffered are the losses of providers, not members, which bear the risk of not being paid.

This Court in its Rehabilitation Order required TWP's providers to continue to service TWP members during the Rehabilitation period. In doing so, the Court recognized that providers are essential to HMO operations. The essential character of these services to an HMO is further evidence that the appropriate category for providers is Class 2, under MCL 500.8142(1)(b).

The Texas receiver for Texas WellChoice argues that under Michigan law, an HMO is not an insurance company, and therefore that claims of providers for services rendered under HMO contracts are not "claims under policies for losses incurred" as required by the language of MCL 500.8142(1)(b) for Class 2 status. The Texas receiver relies for this argument on two cases from the 1980s. The first is a federal bankruptcy case finding that a Michigan HMO would not be deemed an insurance company for purposes of the section of the federal bankruptcy code providing that federal bankruptcy courts do not have jurisdiction over insurance company bankruptcies. *In re Michigan Master Health Plan, Inc,* 90 BR 274 (ED Mich 1985). The second is *Michigan Podiatric*

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[7] In the case of standard medical insurance, the medical provider supplying the insured with the service for which payment is owed is such a third party. To fail to apply the same logic when an HMO rather than a traditional insurance company is paying for the service would be to punish medical providers for doing business with HMO's. This would be not only unfair and illogical but also contrary to the purpose of the 2000 amendment making the Insurance Code applicable to HMO's, as discussed *supra.*

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Medical Assoc v National Foot Care Program, Inc, 175 Mich App 723 732-733; 438 NW2d 349 (1989), which was a suit seeking to bring an unfair insurance competition claim against an HMO.

The Texas receiver's argument is wrong, for several reasons. First, the law has changed fundamentally since the 1980s. On June 29, 2000, the legislature amended the Insurance Code to add Chapter 35, which removes the regulation of HMO's from the Public Health Code and places the regulation of HMO's squarely under the Insurance Code. While recognizing that HMO's are not insurance companies, the legislature, by enacting Chapter 35, made clear its intention to regulate HMO's in the same manner as traditional health insurance companies, including in the context of delinquency proceedings under Chapter 81. See Bill Analysis offered by the Office of Financial and Insurance Services in support of proposed Chapter 35, attached as Exhibit D. Section 3503 of the Insurance Code provides specifically:

> *All of the provisions of this act that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate*, including, but not limited to, section 223 and chapters 34 and 36, *apply to a health maintenance organization under this chapter unless specifically excluded,* or otherwise specifically provided for in this chapter." MCL 500.3503, emphasis added.

The Texas receiver's brief lists all of the statutory sections that are specifically excluded or specifically provided for elsewhere. The list does not include the claim priority section of Chapter 81 or Chapter 81 in general.

Given the change in Michigan law since the decision in *In re Michigan Master Health Plan, Inc,* it is unlikely that this case, which considered the question of whether, for purposes of the United States Bankruptcy Code, HMO's were insurance companies and therefore outside the scope of the United States Bankruptcy Courts, would be decided the same way. A number of bankruptcy cases decided since *Michigan Master Health Plan* have reached the opposite result, finding HMO's to be

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insurance companies for bankruptcy jurisdiction purposes. See *Estate of Medcare HMO,* 998 F2d 436 (7th Cir 1993); *In re GroupHealth Partnership,* Inc, 137 BR 593, (Bankr ED Pa 1992);[8] and *In re Beacon Health, Inc,* 105 BR 178 (Bankr DNH 1989).

Further, the Court in *Michigan Master Health Plan* relied upon a Michigan Attorney General Opinion stating that although HMO's were not to be deemed insurance companies under Michigan law as of the time the bankruptcy court had assumed jurisdiction in that case, it was possible though not certain that even as of that time, a change in Michigan law in 1982, nine months after the bankruptcy had been filed might have led to the conclusion that the HMO was an insurance company for bankruptcy jurisdiction purposes had the bankruptcy been filed later. 90 BR at 277.

Other arguments raised by the Texas receiver (Texas Receiver's Brief at 11) either are irrelevant or actually support payment of the provider claims in Class 2. The fact that HMO's are not permitted to use the name "insurance" is a simple matter of nomenclature, designed to avoid confusion with more traditional insurance carriers, and has nothing to do with how claims against them ought to be paid. MCL 500.3505. And the Texas receiver's argument that "the risk of loss [for medical service payment] is born [sic] by the providers who have contracted with the HMO" rather than by the HMO members (Texas Receiver's Brief at 11) is precisely the Rehabilitator's point. Because the providers bear the risk of loss, their claims are for "losses incurred," and they therefore are entitled to Class 2 status.

F. Malpractice Claimants

Briefs filed on behalf of various medical malpractice claimants argue that these claimants are

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[8] Though this case deemed an HMO an insurance company bankruptcy jurisdiction was allowed, as Pennsylvania's insurance commissioner has discretion not to supervise liquidations.

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entitled to Class 2 treatment. Their argument is that the injuries they have suffered as a result of malpractice are "losses incurred" under the relevant statutory section, MCL 500.8142(1)(b), and therefore they are entitled to Class 2 treatment. The above analysis of the language of the statute together with the nature of the way HMO's do business indicates, however, that this analysis is flawed. As has been shown, it is not the members and patients of TWP, but rather the providers, who bear the risks under the member contracts which are analogous to contracts of insurance, and it is therefore they who suffer "losses incurred."

Moreover, the HMO contract simply is not set up to protect against the effects of malpractice. The malpractice trust fund discussed above was set up to protect against the financial effects of malpractice, and TWP's and its employees' own liability for it. This trust fund is not itself in rehabilitation. It is in fact a separate trust entity, managed by BankOne, with separate assets that cannot be used for any purpose *except* paying malpractice claims. It is currently funded in the amount of over ten million dollars. The parties who potentially suffer losses with respect to the protection it affords are TWP and its employee-practitioners, who are covered from malpractice liability by it. The medical malpractice plaintiffs would be considered third-party loss claimants with respect to this coverage, but not with respect to the HMO contracts that are included in Class 2.

The next question is what class claims by persons claiming injury due to malpractice by TWP or its practitioners do fall in, if not Class 2. The answer seems straightforward under the statute. These persons allege that they have suffered bodily injury from TWP. MCL 500.8142(1)(d) includes as Class 4 claims, "All claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property that are not under policies." The malpractice claims clearly are for

"bodily injury." As explained above, they "are not under policies." Therefore, Class 4 is where these claims belong.

This is the plain meaning of the statutory language. Our Supreme Court has taken pains to emphasize that statutes are to be interpreted by their plain meaning. E.g., *Echelon Homes, supra,* 472 Mich at 196 (""We must give the words of a statute their plain and ordinary meaning. . . .' The plain and ordinary meaning of words can be ascertained by looking at dictionary definitions") (citation omitted); *Koontz v Ameritech Services, Inc,* 466 Mich 304, 323; 645 NW2d 34 (2002) (holding that "courts may not look beyond the clear text of a statute to discover an unexpressed legislative intent"); *Wickens v Oakwood Health Care System,* 465 Mich 53, 60; 631 NW2d 686 (2001) ("If the statute's meaning is clear and unambiguous, we assume that the Legislature intended its plain meaning, and we enforce the statute as written"). This statute's text is clear. Arguments about whose needs are more deserving or who is least able to protect against this kind of loss, whatever their arguable equitable merit, must stand or fall under the framework of the statute as it is written. To the extent the priorities created by the plain language of the statute may seem less than perfectly fair, this argument has to be addressed to the Legislature, not the courts.

G. Manufacturers of Durable Equipment

Home Respiratory Care and Hospital Equipment (Home Respiratory) asserts that it is a small business that maintains $600,000 in inventory annually, primarily to service TWP and its members on an emergency basis. It maintains that its pre-rehabilitation billings and those of similarly situated small business essential equipment suppliers should be given a preferred position in payment. However, no specific statutory authorization for such a preference is shown. Therefore, such claims should receive Class 5 status under MCL 500.8142(1)(e).

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III. CONCLUSION

The Rehabilitator accordingly respectfully asks that the Court enter an Order setting claim priority according to the principles set forth herein, with medical provider claims receiving Class 2 priority, and Home Respiratory Care receiving Class 5 priority. To the extent the Court reaches the issue of a priority for medical malpractice claims outside the trust account, the Rehabilitator asks that medical malpractice claimants receive Class 4 priority.

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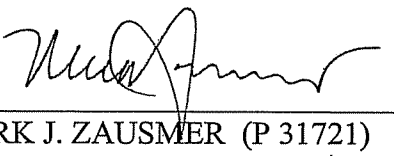

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